STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		056291		B. WING		08/0	9/2008
	ROVIDER OR SUPPLIER ONITA CONVALESCENT HO	DSPITAL	STREET ADDRESS 535 E BONITA A		IP CODE MAS, CA 91773 LOS ANGELE	S COUNTY	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE
	The following reflects to f Public Health during visit.  Representing the Department of Public Health during visit.  Representing the Department of Public Health during visit.  CLASS AA CITATION 95-1313-0005435-F Complaint(s): CA00130 F 323 483.25 (h)(2) adequate supervision prevent accidents.  On February 4, unannounced visit investigate a complain Based on interview investigate a complain Based on inter	artment of Public Head  PATIENT CARE  0756  Each resident ment and assistance  2008, at 8:40 was made to the tof alleged gross negland record review for the tof alleged to the tof alleged gross negland record review for the tof alleged gross negland record grown on the tof alleged grown on the tof alle	Jation  Just receive devices to a.m., an a facility to gligence. The licensed to provide devices by the prevent the promote of the form the licensed to provide devices by the prevent the promote of the licensed to provide devices by the prevent the promote of the licensed to provide devices by the licensed to provide devices by the licensed devices devices by the licensed devices by the				
Event ID	:D1RC11		1/5/2009	8:57:3	1AM		ı
LABORATO	RY DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESE	NTATIVE'S SIGNA	TURE	TITLE		(X6) DATE

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of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State-2567 1 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		056291		B. WING		08/0	9/2008	
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDRESS	CITY STATE	ZIP CODE	l .		
		COLTAI				COUNTY		
CASA BUI	NITA CONVALESCENT HO	JSPITAL	535 E BUNITA A	IVE., SAN DI	MAS, CA 91773 LOS ANGELES	S COUNTY		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIE	s	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION S	SHOULD BE CROSS-	COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMA	TION)	TAG	REFERENCED TO THE APPROF	PRIATE DEFICIENCY)	DATE	
	Continued From page	<b>1</b>						
	failure and venti	ilator dependenc	y, chronic					
	obstructive pulmona	ry disease, atria	l fibrillation,					
	congestive heart failure	e and severe aortic s	tenosis.					
	The respiratory admis	ecion ordore dated	October 22					
	2007, indicated the							
	ventilator and the							
	following: Tidal volun	•						
	the airway during the	e normal breathing	process) of					
	600 cubic centimeter	(cc), 5 liters of ox	ygen and a					
		of 10 and the	mode of					
	assist/control. Accord							
	of Respiratory Care		1					
			. •					
	assist/control means							
	the ventilator. Breath	•						
	to inspiration and	may be volume	or pressure					
	limited.							
	The physician's ord	ler dated October	25, 2007,					
	indicated the residen	t's ventilator setting	mode was					
		to synchronized	intermittent					
	mandatory ventilatio	•						
	,	, ,						
	tolerated. According	_	I					
	Respiratory Care Nint		1					
	means, the resident							
	own and the resid		- 1					
	breaths per minute	from the ventilat	or, but the					
	ventilator would syn	chronize the mach	nine breaths					
	and the resident's own							
	The care plan data	d October 2007	(the enesifie					
	The care plan date							
	date was illegible) ind							
	for becoming disconi							
	to coughing, and	the plan was to	check the					
	ventilator alarms. The	plan of care did not a	address					
Event ID:		ED/OLIDDILES SESSES	1/5/2009		31AM		(VO) DATE	
LABORATOR	Y DIRECTOR'S OR PROVID	EK/SUPPLIER REPRESE	NTATIVE'S SIGNA	JURE	TITLE		(X6) DATE	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL  A. BUILDING			
		056291		B. WING		08/0	9/2008	
	OVIDER OR SUPPLIER NITA CONVALESCENT HO	DSPITAL	STREET ADDRESS, 535 E BONITA A		ZIP CODE MAS, CA 91773 LOS ANGE	LES COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE ACTION REFERENCED TO THE APP	ON SHOULD BE CROSS-	(X5) COMPLETE DATE	
	Continued From page	2						
	the frequency of me. There was no evider record that the facilit the resident's disconnecting from the A review of the lice notes and the vention October 25, 2007 to there was no evide licensed nurses or checking if the ventil that the remote alarm of the place prior to the remote ventilator alarmore.	onitoring the ventil- nce presented or in y provided a device tracheostomy to ventilator tubing.  ensed nurses notes lator monitoring re o October 27, 200 ence to demonstrat respiratory there ator alarms were a was on.  ree 12 there was re resident's death re arms usage. Accor	the clinical e to prevent ube from , respiratory cords dated 07, revealed te that the apists were ctivated and no policy in egarding the ding to the					
	Remote Ventilator A Policy and Procedure and hear the alarr ventilator.  On February 4, 200 asked Employee 5 to by turning off the ventilator alarm alone room. Employee 5 fo type of ventilator Re expired. The evalua	e allows the caregons up to 200 feed 18, at 9:40 a.m., the course of the could be heard out on the could be heard out on the could a resident of the could a resident of the could a resident of the could be heard out to the cou	ne evaluator the situation see if the utside of the note the same gowhen she					
Event ID:	door (approximately the ventilator alarm. to the evaluator detechnician who is company that rents the alarm volume on the company that the alarm volume on the company that rents the alarm volume on the company that th	According to a lette ated August 20, employed by th the ventilators to	er addressed 2008, from e ventilator the facility,	8:57:	31 <b>Δ</b> Μ			
-	Y DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESE			TITLE		(X6) DATE	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		056291		B. WING		08/0	9/2008
	OVIDER OR SUPPLIER NITA CONVALESCENT HO	DSPITAL	STREET ADDRESS, 535 E BONITA A		ZIP CODE MAS, CA 91773 LOS ANGEL	ES COUNTY	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	N SHOULD BE CROSS-	(X5) COMPLETE DATE
	Continued From page	3					
	adjusted, only remote/accessory ala turned back on, it was beeps of two that couthe hallway past the from the patient's roughproximately 50 feet.  During an interview of Employee 11 stated when the staff provishould be turned resident alone. Ho facility representative that existed at the tirprocess.	rm outside of the as a loud high-pitch uld be heard all the nurse's station. Tom to the nurse's on June 5, 2008, at the remote alarm in des care for the result back on before wever, when requivas unable to prove	ed sound in e way down The distance station was to 12:00 p.m., s turned off resident, but leaving the juested the vide a policy				
	A review of the lic Employee 3 dated op.m. indicated the medication, she was 5:30 p.m., Employee resident's tracheostor p.m., the note indica connected to the ventil.  The licensed nurses also indicated, at 6 member returned to resident disconnected how long the resident the ventilator. The revealed the respiration of the resident was unrespondent.	n October 27, 200 nurse gave the rasleep and in no 4's nurses note ramy tube was intacted the tracheostomator.  note written by Eco2 p.m., the reside the facility and from the ventilator thad been discondicensed nurses altery therapists at bedside and caller	esident her distress. At revealed the et. At 5:35 my tube was employee 4 dent's family found the and asked nected from note further and licensed d 911. The				
Event ID:I	D1RC11		1/5/2009	8:57:	31AM		
LABORATOR	Y DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESE	NTATIVE'S SIGNA	TURE	TITLE		(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		056291	B. WING		_ 08/0	9/2008	
	OVIDER OR SUPPLIER NITA CONVALESCENT HO	DSPITAL	STREET ADDRESS, 535 E BONITA AV		ZIP CODE MAS, CA 91773 LOS ANGELE	S COUNTY	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROF	N SHOULD BE CROSS- COMPLETE	
	Continued From page	4					
	status. At 6:30 p.m. the resident dead, ac note written by Employ  A written statement Employee 12 dated 06:00 p.m., she noticed 1's room. She immenoticed Employee 1 air through a tube persons mouth, the down into the lungs) was connecting the she noticed the recyanotic (bluish disconnecting the oxygenatilips and fingertips. Ethe resident for a pshe initiated chest country of the certified nursing At that time Employee 1 rechest compressions	from Employee 3 Dottober 27, 2007, and the commotion adiately went to the bagging (manually that has been intube goes through the resident and It Ambu bag to the cosident was unrespoloration of the blood) amployee 3 proceedulse. There was nompressions and as assistants to get a ee 3 asked had ar lieved her and stand alternated with suctioning. At 6:10 the continued card At 6:30 p.m., the not dead.  The record dated bloyee 1 checked the continued card alternation that the resident and alternated with suctioning. At 6:10 the continued card alternated with suctioning the resident and alternated with succioning the resident and altern	provided by indicated at in Resident e room and y squeezing serted in a the trachea Employee 9 bygen tank. Sonsive and a caused by around her ed to check o pulse, so sked one of backboard. Syone called arted doing h Employee sident orally p.m., the diopulmonary paramedics  October 27, ne ventilator d 5:05 p.m.				
Event ID:I			1/5/2009	8:57:			
LABORATOR	Y DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESE	NTATIVE'S SIGNAT	URE	TITLE		(X6) DATE

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STREET ADDRESS, CITY, STATE, 2P CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
CASA BONITA CONVALESCENT HOSPITAL   S35 E BONITA AVE., SAN DIMAS, CA 91773 LOS ANGELES COUNTY			056291				08/0	9/2008	
PREFIX   EACH DEPICIENCY MUST BE PRECEDED BY PILL   PREFIX   (EACH CORRECTIVE ACTION SHOULD BE CROSS-TOTAL TOTAL STATE   PREFIX   TAG   REPERENCED TO THE APPROPRIATE DEPICIENCY)   Date			DSPITAL				ES COUNTY		
According to the Respiratory Therapy Progress Notes written by Employee 1 dated October 27, 2007, at 6:00 p.m., the resident was found unresponsive. There was no mention of the resident being found disconnected from the ventilator as indicated in Employee 1's interview with the evaluator. The progress note did not address whether the remote alarm or the ventilator alarms were checked.  During an interview on February 4, 2008, at 9:30 a.m., Employee 5 said the ventilators are checked every six hours according to their policy, unless there is something wrong with the resident then they check the ventilator as needed. However, there was no documentation to show the remote alarm was checked. The evaluator obtained a copy of the policy Employee 5 referred to, but the policy was not dated.  On February 5, 2008, the ventilator technician, who is employed by the ventilator company that rents the ventilators to the facility, downloaded the information from the computer within the ventilator that Resident 1 was using when she expired. According to the technician's review and interpretation of the printout the following events took place on October 27, 2007 around the time the resident expired:  □ 3:36 p.m., the change of pressure alarm was activated.  □ 3:38 p.m., the remote alarm (the alarm outside of the room on the wall that coincides with the alarm on the ventilator) was silenced and turned off.  □ 4:50 p.m., the inspiration alert was activated and	PREFIX	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION	ON SHOULD BE CROSS- COMPLETE		
Notes written by Employee 1 dated October 27, 2007, at 6:00 p.m., the resident was found unresponsive. There was no mention of the resident being found disconnected from the ventilator as indicated in Employee 1's interview with the evaluator. The progress note did not address whether the remote alarm or the ventilator alarms were checked.  During an interview on February 4, 2008, at 9:30 a.m., Employee 5 said the ventilators are checked every six hours according to their policy, unless there is something wrong with the resident then they check the ventilator as needed. However, there was no documentation to show the remote alarm was checked. The evaluator obtained a copy of the policy Employee 5 referred to, but the policy was not dated.  On February 5, 2008, the ventilator technician, who is employed by the ventilator company that rents the ventilators to the facility, downloaded the information from the computer within the ventilator that Resident 1 was using when she expired. According to the technician's review and interpretation of the printout the following events took place on October 27, 2007 around the time the resident expired:  3:36 p.m., the change of pressure alarm was activated. 3:38 p.m., the remote alarm (the alarm outside of the room on the wall that coincides with the alarm on the ventilator) was silenced and turned off. 4:50 p.m., the inspiration alert was activated and		Continued From page	5						
is employed by the ventilator company that rents the ventilators to the facility, downloaded the information from the computer within the ventilator that Resident 1 was using when she expired.  According to the technician's review and interpretation of the printout the following events took place on October 27, 2007 around the time the resident expired:  3:36 p.m., the change of pressure alarm was activated.  3:38 p.m., the remote alarm (the alarm outside of the room on the wall that coincides with the alarm on the ventilator) was silenced and turned off.  4:50 p.m., the inspiration alert was activated and		Notes written by E 2007, at 6:00 p.m. unresponsive. There is being found disconrindicated in Emplo evaluator. The progwhether the remote were checked.  During an interview a.m., Employee 5 sa every six hours accepted there is something they check the ventila was no documentatic was checked. The expolicy Employee 5 renot dated.	mployee 1 dated was no mention of nected from the value of the vention of alarm or the vention of the vention on February 4, 20 and the ventilators according to their powrong with the relator as needed. However, aluator obtained a eferred to, but the	October 27, was found the resident ventilator as with the not address lator alarms  O8, at 9:30 are checked olicy, unless esident then wever, there emote alarm copy of the policy was					
LABORATORY DIRECTOR'S OR PROVIDER/SLIPRI IER REPRESENTATIVE'S SIGNATURE TITLE (VS) DATE	Event ID:	is employed by the the ventilators to information from the that Resident 1 wa According to the interpretation of the took place on Octobersident expired:  3:36 p.m., the cactivated.  3:38 p.m., the rem the room on the wal on the ventilator) was said 4:50 p.m., the inspiration	ventilator company the facility, down computer within the s using when s technician's re printout the follow er 27, 2007 around hange of pressure note alarm (the alarm ill that coincides wite silenced and turned of	y that rents alloaded the ne ventilator he expired. eview and wing events the time the alarm was moutside of the he alarm off.	8:57:	31AM			
			FR/SLIPPLIED DEDDESE			TITLE		(X6) DATE	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		056291		B. WING		_ 08/0	8/09/2008	
	OVIDER OR SUPPLIER NITA CONVALESCENT HO	OSPITAL	STREET ADDRESS, 535 E BONITA A		ZIP CODE MAS, CA 91773 LOS ANGELE	ES COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	N SHOULD BE CROSS- COMPLETE		
	Continued From page	6						
	remained activated unt 5:27 p.m., the remand silenced. Also, setting alarm was actived 6:19 p.m., the remote According to a letter (addressed to the eventh times because of determined that may cause the activate are coughind disconnected from change of pressure change in pressure change in pressure changes the settings alarm is an accessiventilator located outsing. The down loaded inspiration alert alarm activated for 37 min p.m. One half and found the resident defined and unresponsive.  On February 7, 20 telephone interview, unaware of the care that indicated the resident's ventilated to congestion the resident's ventilated the patients are that other patients are that of the care that of the congestion the resident's ventilated to the patients are that of the patients are that the patients are th	il 5:27 p.m. note alarm was turr at that time the rated. e alarm was silenced from the ventilator aluator) he added aylight savings time. Sian also stated the inspiration aler g, and the patier the ventilator or alarm indicated of the air being delirigh, too low or not g alarm sounds whom the ventilator. Sory alarm connected from the ventilator income was activated arrutes from 4:50 p.m. hour later the familisconnected from the ventilator diet in the plan written by Edident was at risk for the ventilator due in the indicated there was activated of the rowas activated	change of  I. or technician one hour to the conditions one hour to the coming death. The there is a the conditions of th					
Event ID:I	⊥ D1RC11		1/5/2009	8:57:	31AM		I	
LABORATOR	Y DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESE	NTATIVE'S SIGNA	TURE	TITLE		(X6) DATE	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		056291		B. WING		08/0	9/2008	
NAME OF PROVIDER OR SUPPLIER  CASA BONITA CONVALESCENT HOSPITAL  STREET ADDRESS, CITY, STATE, ZIP CODE  535 E BONITA AVE., SAN DIMAS, CA 91773 LOS ANGELES COUNTY				ELES COUNTY				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACT	N OF CORRECTION TION SHOULD BE CROSS- PROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	Continued From page	7						
	Resident 1 "every 5 to say the facility's check the ventilator it more than every 6 The evaluator obta Employee 1 was refe There was no discularm and nothing addressed that the Employee 1 stated high when Resident 1's filled He did not hear the resident's room he disconnected from the went on to say the ventilator. Some and he and the cardiopulmonary resexpired.	policy indicated the every 6 hours, but hours but did not ined a copy of irring to, but it was ussion regarding continuing in the clinical remote alarm was new as at the number alarms. When he is noticed the reconnected the one brought in the	ey were to he checked document it. the policy is not dated. hecking the record that is monitored. rse's station ed for help. got to the sident was nresponsive. resident to e crash cart es initiated					
Event ID:	On February 21, 2008, at 9:45 a.m., an interview with the resident's family member revealed she visited Resident 1 at the same time everyday for several weeks and had not seen the nurses or respiratory therapists check the alarms. The Family Member went on to say on many occasions she visited the resident and discovered the remote alarm had been turned off, and reported it to Employee 2. On October 27, 2007 she left the facility to pick up her father at 5 p.m., and returned at 6 p.m., the same routine everyday. When she returned, she noticed the resident was disconnected from the ventilator, unresponsive and that the remote alarm was not sounding. She yelled for help and Employee 1 was the first to respond.			8:57:	31AM			
LVCIIL ID.L	511.011		1,5/2000	0.07.	e utl			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER NITA CONVALESCENT HO	DSPITAL	STREET ADDRESS 535 E BONITA A		ZIP CODE MAS, CA 91773 LOS ANGELE	ES COUNTY		
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	Continued From page	8						
	According to the F checked the resident to get him an oxyg stated she yelled to that, the staff was ruknow what to do.  During an interview of Employee 2 stated she was off duty but the facility, but could caller told her Reside the machine was o stated when she car was still in the resi ventilator alarm and went on to say when no policy in place Remote Ventilator A Policy was created the resident expired.  The facility failed to:  1. Have a system in tracheostomy tube ventilator tubing, who cause of the resident's 2. Monitor that the outside the resident's 2. Monitor that the outside the resident's 3. The above violations combination presented that death or ser substantial probability to the staff of the service of	Family Member, Estand told the Family and told the Family member tank. The Family member to get of the nurses to get of the nurses to get of the day the resident received a call at not remember who ent 1 expired and the number of the told the term of the told the term of the told the term of t	nily Member nily Member oxygen. After they did not to take they did not take they					
Event ID:[	⊥ D1RC11		1/5/2009	8:57:	31AM		1	
LABORATOR	Y DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESE	NTATIVE'S SIGNA	TURE	TITLE		(X6) DATE	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		056291		B. WING		08/09	9/2008	
	OVIDER OR SUPPLIER NITA CONVALESCENT HO	DSPITAL		ODRESS, CITY, STATE, ZIP CODE NITA AVE., SAN DIMAS, CA 91773 LOS ANGELES COUNTY				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	I SHOULD BE CROSS-	(X5) COMPLETE DATE	
	Continued From page	9						
	physical harm would proximate cause of dea	d result and wa	s a direct					
Event ID:[	 D1RC11		1/5/2009	8:57:3	1AM			
LABORATOR	Y DIRECTOR'S OR PROVIDI	FR/SUPPLIER REPRESE	NTATIVE'S SIGNA	TURF	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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